PRINTED: 03/16/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION **TATEMENT OF DEFICIENCIES** COMPLETED IDENTIFICATION NUMBER: **ID PLAN OF CORRECTION** A. BUILDING C B. WING

AME OF PROVIDER OR SUPPLIER

SE

445223

STREET ADDRESS, CITY, STATE, ZIP CODE

RENAISSANCE TERRACE CARE AND REHABILITATION CENT	TER	257 PATTON LANE HARRIMAN, TN 37748			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a physician's order to transport to a hospital for one resident (#7) of sixteen sampled residents. The findings included: Medical record review revealed Resident #7 was admitted to the facility on January 17, 2007, with diagnoses including Schizophrenia. Medical record review of a psychologist's progress note dated December 14, 2010, revealed, "will consider hospitalizationfor beh (behavior) secondary Thought disturbance/labile mood" Medical record review of a nurse's note dated December 17, 2010, at 10:20 a.m., revealed, "Res (resident) left for (hospital) behavior unit" Medical record review of a nurse's note dated December 30, 2010, revealed the resident returned to the facility from the hospital. Medical record review revealed no physician's order regarding transport and/or evaluation/treatment of Resident #7 at a hospital on December 17, 2010. Interview with the director of medical records on March 8, 2010, at 1:32 p.m., in a conference room, revealed the facility was unable to locate a physician's order to send the resident to a	F 2	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Renaissance Terrace Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." F281 1. Resident #7's physician was notified of transport to the hospital on December 17, 2010 by the unit manager. 2. Other discharged/transferred resident charts were reviewed for transport orders by the Health Information Manager and the Director of Nursing Service completed on March 24, 2011. Any identified issues were communicated to the physician by a licensed nurse by March 25, 2011.			
RATORY DIRECTOR'S OR PROVIDER/SURPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE (X6) DATE			

DMINISTRATOR

03/11/2011

eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that reguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days g the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ollowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ım participation.

MAR 2 of continuation sheet Page 1 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 03/16/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		445223	B. WING	3	C 03/11/20	11
	PROVIDER OR SUPPLIER SANCE TERRACE CA	RE AND REHABILITATION CENT	Sacres	STREET ADDRESS, CITY, STATE, ZIP CODE 257 PATTON LANE HARRIMAN, TN 37748		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COM	(X5) MPLETION DATE
	PROFESSIONAL S The services provide must meet profession This REQUIREMENT by: Based on medical rethe facility failed to obtransport to a hospit sixteen sampled res The findings include Medical record reviet admitted to the facility diagnoses including record review of a period of the facility diagnoses including record review of a period of the facility diagnoses including record review of a period of the facility of the facil	ed or arranged by the facility onal standards of quality. IT is not met as evidenced ecord review and interview, obtain a physician's order to al for one resident (#7) of idents. d: w revealed Resident #7 was by on January 17, 2007, with Schizophrenia. Medical eychologist's progress note 2010, revealed, "will ionfor beh (behavior) disturbance/labile mood" w of a nurse's note dated at 10:20 a.m., revealed, or (hospital) behavior unit" w of a nurse's note dated revealed the resident of a nurse's nurse's note	F 28	3. Re-education completed on 27, 2011, was provided for the licensed staff by the Director of Nursing Services and Staff Development Coordinator regard obtaining and writing an order the physician prior to resident transport and/or discharge. 4. Any transported or discharge residents medical record will be reviewed weekly by the Direct Nursing Services or Nursing Supervisors for 1 month and me for three months. The findings presented by the Director of Nin the monthly Performance Improvement (PI) Meeting for recommendations. The Performance Improvement Committee inclusive Administrator, Assistant Administrator, Medical Director of Nursing Services, Assistant Directors of Nursing Services Director, Activities Deservices Director, Clinical Casa Manager, MDS Coordinator, I Control Nurse, Maintenance Dand Pharmacy Consultant.	of arding from ged be or of nonthly s will be ursing further rmance ides the or, , Social birector, tritional e infection birector,	29/11
		R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(X6) DAT	TE

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

Facility ID: TN7301

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

	The second secon	HAAD HUMAN SERVICES				FORM	: 03/16/201 APPROVE : 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION (2	X3) DATE SI COMPLE	URVEY
		445223	B. WI	NG	7.117.001.000	03/1	C 1/2011
	PROVIDER OR SUPPLIER SANCE TERRACE CA	RE AND REHABILITATION CENT	ΓER	25	EET ADDRESS, CITY, STATE, ZIP CODE 17 PATTON LANE ARRIMAN, TN 37748	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 281 F 425 SS=D	March 11, 2011, at a facility failed to obta transport and/or eva hospital on Decemb	with the administrator on 3:45 p.m., confirmed the in a physician's order to eluate/treat Resident #7 at a er 17, 2010. MACEUTICAL SVC -	F 2		<u>F425</u>		3/29/11
	The facility must pro	vide routine and emergency			1. The pharmacist and physician		

drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced Based on medical record review and interview, the facility failed to provide pharmaceutical services to ensure the accurate dispensing and administering of controlled medications for one resident (#1) of sixteen sampled residents.

notified by the Administrator and the Director of Nursing on March 12, 2011 regarding resident #1's medical record recapitulation summary, controlled substance record and medication regimen.

2. Other resident's medical records were reviewed by the nursing management team on March 12, 2011, to compare physician orders with the controlled substance record. Pharmacy staff will complete a review by March 28, 2011 of other resident's physician orders, medication administration record and pharmacy labels. Any identified issues will be corrected and physician notification will occur by March 28, 2011.

RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PXUU11

Facility ID: TN7301

If continuation sheet Page 2 of 7

DEPARTMENT OF HEALTH A ... D HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DE	FICIEN	CIES
AND PLAN OF	COR	RECTIC	N

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

445223

B. WING ____

C 03/11/2011

NAME OF PROVIDER OR SUPPLIER

RENAISSANCE TERRACE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 257 PATTON LANE

KENAIS	SSANCE TERRACE CARE AND REHABILITATION CEN	TER	HARRIMAN, TN 37748		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE	
	The findings included: Resident #1 was admitted to the facility on November 15, 2010, with diagnoses including Arthritis and Chronic Osteomyelitis of Left Lower Extremity. Medical record review of a physician's order dated November 13, 2010, revealed, "Valium (anti-anxiety medication)(Diazepam) 5 mg (milligram) tablet by mouthEvery eight hours Everyday" Medical record review of a physician's order dated January 12, 2011, revealed, "Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 by mouthEveryday, 0000 0400 0800 1200 1600 2000 (12:00 a.m. 4:00 a.m. 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.), Give one tab (tablet every 4 hours routinely while awake." Medical record review of recapitulation (summary) orders dated January and February, 2011, revealed the orders for the medications remained current physician orders. Continued review revealed the resident did not have orders for PRN (as needed) Valium or Hydrocodone. Medical record review of an Individual Patient's Controlled Substances Record dated January 30, 2011, through February 9, 2011, revealed, "Diazepam 5 mg tabletTake 1 tab (tablet) by mouth three times daily and take 1 tab by mouth three times daily as needed" Continued review revealed the medication was not signed out on February 6th or 9th, 2011, at 12:00 a.m. and no medication was used at times other than 12:00 a.m., 8:00 a.m., and 4:00 p.m. Medical record review of an Individual Patient's Controlled Substances Record dated February 11, 2011, revealed, "Hydrocodone/Acetamin	F 42	3. Re-education for licensed nurses was provided by the Director of Nursing Services and Staff Development Coordinator on physician order verification, transcribing orders, completing the medication administration record and controlled substance record. This reeducation was completed on March 19, 2011. The facility pharmacist was re-educated on March 26, 2011, by the pharmacy supervisor, on medication regimen, reviews, and pharmacy medication labeling and identifying pharmacist that completes review on the record. 4. Review of the medication administration record and controlled substance records for signatures will be completed by the Director of Nursing or Nursing Supervisors weekly for 1 month and monthly for 3 months. The Director of Nursing or Nursing Supervisors will review the medication regimen reviews for pharmacist name monthly for 3 months. The findings will be presented by the Director of Nursing monthly for three months in the monthly Performance Improvement (PI) Meeting for further recommendations. The pharmacy		
			The pharmacy	- 1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 03/16/2011

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				M APPROVI D. 0938-03
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	(X3) DATE COMP	SURVEY LETED
		445223	B. WIN	G	03/	C 11/2011
	SUMMARY STA	RE AND REHABILITATION CENT	- 1	STREET ADDRESS, CITY, STATE, ZIP 257 PATTON LANE HARRIMAN, TN 37748 PROVIDER'S PLAN OF 0	CODE	
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE
	10-325 tablet1 tab needed for pain" O medication was sign 2011, the time was i the entry, and the co- Continued review re- not signed out on Fe 4:00 a.m. Medical record revier Reviews dated Febru irregularities were ide the pharmacist's nan- Telephone interview Nursing on March 11 revealed the facility of substance record for anxiety medication a mislabeled Individual Substances Records anxiety medication. Telephone interview was March 11, 2011, at 3: pharmacy consultant regarding the residen March 11, 2011, and was unavailable for in confirmed the facility's to provide pharmaceus ensure accurate disper-	by mouth every 4 hours as continued review revealed the ned out on February 13, llegible, a line drawn through ount remained the same. We aled the medication was abruary 13 or 14, 2011, at word a Medication Regimentary 4, 2011, revealed not entified and failed to identify ne. with the Interim Director of 1, 2011, at 1:25 p.m., lid not have a controlled the resident's routine pain or and the facility had used Patient's Controlled for the resident's pain and with the administrator on	F 4:	supervisor will review the facility pharmacy r irregularities. The find presented to the month Improvement Committe recommendations, to e compliance with pain r. The Performance Improcommittee includes the Administrator, Assistan Administrator, Medical Director of Nursing Ser Assistant Directors of N Services Director, Activ Housekeeping Supervis Service Director, Clinic Manager, MDS Coordin Control Nurse, Mainten and Pharmacy Consulta	review for dings will be ly Performance tee for further ensure management. ovement e la Director, rvices, Jursing, Social vities Director, sor, Nutritional cal Case mator, Infection ance Director,	3/29/11

RM CMS-2567(02-99) Previous Versions Obsolete

483.75(I)(1) RES

Resident #1.

C/O: #27415

F 514

SS=D

regarding provision of pharmacy services for

RECORDS-COMPLETE/ACCURATE/ACCESSIB

Event ID: PXUU11

Facility ID: TN7301

F 514

If continuation sheet Page 4 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/16/2011 91

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				1 APPROVE). 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/S IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		445223	B. WING			C 1 1/2011
	PROVIDER OR SUPPLIER SANCE TERRACE CA	RE AND REHABILITATION CENT	- 1	TREET ADDRESS, CITY, STATE, ZIP COD 257 PATTON LANE HARRIMAN, TN 37748		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 4	F 514	4 <u>F514</u>		3/29/11
	resident in accordar standards and pract accurately document systematically organ. The clinical record information to identification to i	nust contain sufficient fy the resident; a record of the ents; the plan of care and		 The physician was notifically Director of Nursing Services 12, 2011 of resident #1's consubstance record and medical administration record. Other resident's medical medication administration record reviewed on March 24, 201 nursing management team. 	e on March ontrolled cation records, records and s were 1 by the	
	by: Based on medical re the facility failed to m medica record for or sampled residents. The findings included Resident #1 was adm November 15, 2010, Arthritis and Chronic Extremity. Medical re order dated November "Valium (anti-anxie)	cord review and interview, naintain a complete, accurate the resident (#1) of sixteen d: chitted to the facility on with diagnoses including Osteomyelitis of Left Lower ecord review of a physician's ter 13, 2010, revealed, ty medication)(Diazepam) 5 by mouthEvery eight hours		residents were affected. 3. Licensed nurses were reby the Director of Nursing Staff Development Coordinadministering medications documentation of administer medications and correct lab controlled substance recordeducation was completed or 28, 2011	educated Services or nator on as ordered, ering eling of s. This re-	

physician's order dated January 12, 2011,

revealed, "Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 by mouth... Everyday, 0000 0400 0800 1200 1600 2000 (12:00 a.m. 4:00 a.m. 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.), Give one tab (tablet every 4 hours

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPL	
		445223	B. WIN	G	03/	11/2011
	PROVIDER OR SUPPLIER SANCE TERRACE CA	RE AND REHABILITATION CENT	ER	STREET ADDRESS, CITY, STATE, ZIP COI 257 PATTON LANE HARRIMAN, TN 37748	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	routinely while awak recapitulation (summand February, 2011, medications remained Administration Record 2011, revealed Validadministered on February 13 and Medical record review regarding an explanationitials. Medical record review regarding an explanationitials. Medical record review regarding an explanationitials. Medical record review Controlled Substance 2011, through February 5 mg table mouth three times daily as m	de." Medical record review of mary) orders dated January revealed the orders for the ed current physician orders. We of a Medication rd (MAR) dated February, m 5 mg was not initialed as ordered with the first of the modern of the circle of	F 5	4. A review of medical completeness will be con Health and Information I residents per week for 4 monthly for 2 months. To f Nursing or Nursing St complete a review of me administration records are substance records for cor and documentation on 5 week for 4 weeks, then months. The findings wipresented by the Director to the Performance Improvementation on 5 meeting for further reconsultation on 5 meeting for further reconsultation. The Performance Improvementation of Nursing Service of Nursing Services Director, Activit Housekeeping Supervisor Service Director, Clinical Manager, MDS Coordinat Control Nurse, Maintenant and Pharmacy Consultant.	mpleted by the Manager on a weeks, then The Director upervisor will dication and controlled rect labeling residents per nonthly for 2 ll be of Nursing overnent (PI) nmendations rement Director, ices, rsing, Social ies Director, Nutritional Case tor, Infection ice Director, in the control of the control o	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		445223	B. WII			03/	C 11/2011
	PROVIDER OR SUPPLIER SANCE TERRACE CA	RE AND REHABILITATION CENT	ΓER	2	REET ADDRESS, CITY, STATE, ZIP CODE 57 PATTON LANE IARRIMAN, TN 37748		11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Nursing on March 1 revealed the facility substance record fo anxiety medication. the facility had used Patient's Controlled resident's pain and a confirmed the facility	with the Interim Director of 1, 2011, at 1:25 p.m., did not have a controlled r the resident's routine pain or Continued interview revealed mislabeled Individual Substances Records for the anxiety medication, and r had failed to maintain a medical record for Resident	F	514			